

Clinical and Administrative Leadership in Community-Based Residential Programs

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Summary

Oregon's Public Mental Health System includes a continuum of small community – based residential programs offering mental health treatment and 24/7 personal care support for adults experiencing severe mental illness. A team of several mental health paraprofessionals working under the direction of the facility administrator and the Master level therapist strive to gently challenge residents to set personally meaningful goals, practice functional skill and slowly take charge of their lives in the community. The author asserts that the manner in which daily operational and behavioral challenges are resolved by the team, affects residents' lives not less than strictly therapeutic interventions. This paper has a twofold aim: 1) To characterize leadership, organization and staff communication as building blocks of the collaborative, person-centered and strength-based residential treatment; 2) To show how clinical and administrative processes must interplay to create a spirit of recovery and optimism in the home-like community residential facilities.

recovery; residential treatment; clinical and administrative leadership

This manuscript is dedicated to Robert C. Beckett, late Executive Director of Columbia Care Services, Inc.

The views and opinions expressed in this article are those of the author and do not necessarily reflect the official policy or position of Columbia Care Services, Inc.

INTRODUCTION

Management practices in small community-based residential programs have no less impact on the therapeutic milieu than strictly clinical interventions. Living for a long time in the structured environment with 24/7 staff support may foster dependency instead of preparing residents for a real world [1]. A survey of Oregon's residential programs conducted in the year 2010 revealed that the majority or resi-

dents “got stuck” in the system. They reported not feeling ready for community living [2]. Depending on the leadership style, organizational structure and staff communication patterns, residential programs may function primarily as a safety net, or may stimulate residents' motivation and enthusiasm for community living [3]. According to their formal job descriptions, residential administrators are ultimately responsible for providing leadership and direction to the therapeutic environment. Infusing congregated living settings with hope, optimism and a sense of community is by no means simple. It requires seamless collaboration with the residential therapist in deliberately translating the principles of recovery into administrative and clinical practices [4]. In addition, the manner in which facility leaders deal with a plethora of small operational problems, becomes a real test whether or not residential programs can truly be person-centered, strength-based and collaborative [5]. Drawing

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on his own experience, the author formulates the following suggestions to address this challenge.

LEADERSHIP

Using real life examples, the administrator and the supervising therapist explain to the team how daily routines can support the overall program purpose, for example how to equalize relationships between residents and staff, and emphasize what they have in common instead of what divides them? What do staff do to facilitate practical orientation and sense of working together? How are disagreements between residents handled? Do residents and staff share meals together? Do staff make all medical appointments for residents? Can residents keep food in their rooms? Unless recovery principles are clearly translated into concrete practices, residential staff may conclude that their facility goals are either unrealistic, or residents are “too sick” and “unmotivated” to benefit from their therapeutic program [6]. Residential leaders pay attention to maintaining a low stimulation, relaxed learning environment in which all residents, irrespective of their level of functioning, can succeed in acquiring skills consistent with their personal goals and the expectations of community living. The learning aspect of the residential environment is rooted in the classical model of the therapeutic community [7]. In practice, staff may struggle how to balance support for residents’ independence with the need to provide personal care. They may do something for a capable resident and at the same time, insist that a resident lacking self-confidence completes a particular task independently. In addition, person’s capacity for independent action may frequently fluctuate, for example the same resident may be able to clean his/her bedroom independently one day and require full assistance another day. Facility leaders must prevent staff from jumping to the conclusion that residents are “lazy” before considering other possible explanations, e.g. cold symptoms.

Incidental mistakes are considered natural and even necessary in the learning process. Program leaders show staff how to measure slow progress in incremental steps and how to acknowledge residents for their improvements and ef-

forts. This is essential for building residents’ motivation to learn skills. This is also necessary for sustaining a high-quality therapeutic environment over a long period and preventing the staff from feeling helpless and pessimistic. In order to create and maintain a cohesive organizational culture, program leaders gather input from the staff before making important program decisions. Such consultative decision-making cannot be confused with the majority vote, which is typically indicative of absent leadership. Aside from crises when communications must be timely and concise, the administrator and the residential therapist always consult with each other and take time to weigh pros and cons before making important decisions affecting lives of residents [8]. The administrator and the residential therapist spend sufficient time away from their offices to model respectful and empathetic communication with residents, without directly telling staff what to do every step of the way.

ORGANIZATIONAL STRUCTURE

Staffing pattern and shift coverage are adequate to program needs. For the staff it means having a stable work schedule without frequent changes and demands for overtime, knowing on arrival to work what to expect during the shift, being able to move through daily routines with minimal distractions; and having a shift partner present at work as scheduled. For residents it means being able to plan, having less difficulties remembering what is expected, more likely showing up on time for scheduled appointments, and avoiding unnecessary stress and frustration. Residential staff have the protected time for quality interactions with residents. Daily work schedule balances necessary tangible tasks (such as medication administration, meal preparation, transportation, cleaning and documentation) with the need for person – centered social interactions.

Weekly house meetings provide a democratic forum for residents and staff to clarify mutual expectations, brainstorm solutions to house-keeping issues or plan house wide activities. Through this process resident and staff practice how to make positive requests, express opinions, listen to each other and reach compromises. Res-

idents are engaged in the operation of the facility whenever it is safe, feasible and legal. For example, staff and resident can clean the house together, prepare communal meals, wash dishes, shop for groceries, or conduct facility safety inspections. This brings a sense of community and uses natural learning potential of staff and residents working together [9].

House rules are simple, straightforward and designed specifically to protect resident safety and welfare. Residents and staff are not trapped in situations in which rules prevent them from using their best judgment in decision-making. Staff can have flexibility to grant residents' requests when it is feasible and safe instead of rigidly adhering to rules without explaining them to residents, e.g. Residents can watch TV at night in a common area as long as they keep volume low and do not disturb other residents. House rules need to be both practical and consistent with the overall therapeutic approach. For example, while residents must be protected from financial exploitation, forbidding voluntary monetary transactions is almost impossible to enforce, it may increase the risk of power struggles, and it does not allow residents to learn from their own mistakes

The team has a system for sharing pertinent information across the shifts. In addition to using a communication log, staff benefit from having brief daily cross shift meetings with the supervising therapist to address residents' outstanding issues and divide daily tasks between shift partners. This allows the team to maintain a consistent therapeutic approach, irrespective of individual personal opinions.

STAFF COMMUNICATION

Program leaders serve as role models of effective negotiation skills. They show to the team their ability to reach reasonable compromises with staff and residents. Compromising is the basis of the collaborative residential culture based on the mutual respect. For the collaboration to exist, there must be general understanding among management, staff and residents regarding their mutual expectations. All three parties must strive to listen to each other. Mutual agreements must be concrete enough to keep parties accountable

and each party needs to demonstrate some flexibility [10]. Staff express positive regard toward residents with emotionally neutral empathy and acceptance. Criticizing residents in front of their peers and out of personal frustration is considered unacceptable. Staff are also discouraged from making loud enthusiastic comments that can be overwhelming to residents [11].

The team earns credibility and trust of residents by constructively problem-solving various disruptions in daily routines, for example caused by last-minute sick calls, pharmacy not sending medications on time or sudden behavioral escalations. Resolving such issues without the public display of interpersonal tension, has a positive modeling effect on residents who often observe how staff treat each other in difficult situations. Staff are expected to spend sufficient time with residents and offer them undivided attention. Management consistently discourages staff from speaking with residents over their office counter or having conversations with them and at the same time, being engaged in other tasks, e.g. typing on the computer, reviewing documentation. Team members understand the difference between dangerous behavior, which requires emergency response, and disruptive behaviors, which does not pose an imminent risk of injury. Program leaders coach staff in managing disruptive behavior without emotionally charged overreaction. Instead, staff allow time for the behavioral management plan to be developed deliberately under the guidance of the supervising therapist. The program administrator guides team members to support each other in maintaining composure under difficult and stressful conditions. Team members use the same respectful and jargon-free language in speaking about residents with or without their presence. Management and residential staff members share their observations about residents in neutral behavioral terms instead of attaching to them such stigmatizing, institutional labels as "manipulator", "staff splitter", "attention seeker" or "non-compliant". The supervising therapist reframes problematic behavior into social skills, which residents would have to learn to assert their needs effectively, e.g. by making a firm, calm request instead of yelling [12].

All incidents of physical altercations are promptly debriefed with residents by the super-

vising therapist and/or administrator. Such debriefing is intended solely to provide emotional relief to residents. This is not the time to analyze a chain of events leading the incident. Residents are encouraged to openly express their feelings about the incident. Staff validate these feelings and provide reassurance to residents who are not feeling safe and are in need of additional individual support. Program leaders also promptly conduct separate debriefing with team members who witnessed the incident. Working for the extended period of time in a residential setting is stressful and may produce counterproductive behavior associated with compassion fatigue, like apathy or abruptness. Residential staff need the proper venue to talk about emotional aspects of their work away from residents [13].

CONCLUSION

This text outlines clinical and administrative management practices supporting a recovery-oriented therapeutic culture in small, community-based residential homes and facilities. Instead of turning into mini institutions where the emphasis is placed on compliance with internal rules, these home-like settings can provide a normalized learning environment based on external, community standards [14]. For this to happen, the team must avoid a mindset of control. Management practices briefly described in this text strive to consistently infuse residents with hope and optimism, and residential teams – with calm perseverance, compassion and discipline.

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